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PERSONAL RISK AND SOCIAL RESPONSIBILITY: WHAT IS THE ROLE OF INSURANCE IN THE AGE OF ENTITLEMENT?

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DR. CARL J. SCHRAMM: Exhibit 1 shows that there was a demand shift for health care in 1965. The Congress declared, as an entitlement, that everybody could get into a hospital regardless of income or age. We used to really worry about income being the vector of our policy because old people used to be very poor, and Medicare and Medicaid basically were designed to give people access to health care.

The demand curve shifted out immediately. The price spiral started. We've never had it under control since. One of the reasons we haven't is because of the political formula worked out principally with doctors; less so with hospitals.

The government decided or promised to pay providers for the government's patients, which now account for about 45% of all the hospital revenue, and similar amounts of money for physicians. They'd pay whatever was reasonable as it was determined by the individual provider.

So, this cycle kicked off and our whole effort ever since, on the public side, on the private side, on the Blue Cross side, on the commercial insurance side and on the employer side has been to contain the price spiral.

Graph 1 shows you the surge in hospital costs and in hospital use that happened immediately after 1965. We don't dare show the post-1970 experience because the graph isn't big enough. It would have to be as high as the Hancock Tower to get the rest on at this matrix. Graph 2 shows physician fee increases, 1966-1970. The point of the last two graphs makes the case that you can in fact identify 1965 as the sea change moment in which all of these forces began to move in the same direction.

Who am I to tell you? Those of you who wrestle on a daily basis trying to figure out rates inside an insurance company -- the actuaries among you doing the health work -- know this. This is the commonplace experience. Those of you who are older know firsthand what this meant the post-1965 era -- relative to how calm your jobs had to have been prior to 1965.

Graph 3 tells us our loss ratios, 1965-1986, for both Blue Cross and the commercial insurance world. The HIAA has recently commissioned the first systematic studies of cycles in the health line. It's being done by Professor Roger Formisano at the University of Wisconsin.

If we go back to 1950, we would basically see a very modest trend and not even much cycle in the health line. In 1965, we basically begin to see the introduction of the cycle phenomenon, which is a very important aspect of everything I'm going to talk about.

In a sense, what I am going to stress is that this cycle predicts all of our problems; the cycle is the chaos. Everything else we speak about is reactive to the cycle. Indeed, I mean to include with some reservation much of technological innovation that I would venture to say relates to, in fact, changes in social behavior induced by the perception of the cycle and how we finance.

Graph 4 shows our group health insurance performance as a percent of gain or loss, on the bottom, against the national health care expenditures from our national income accounts. The point I

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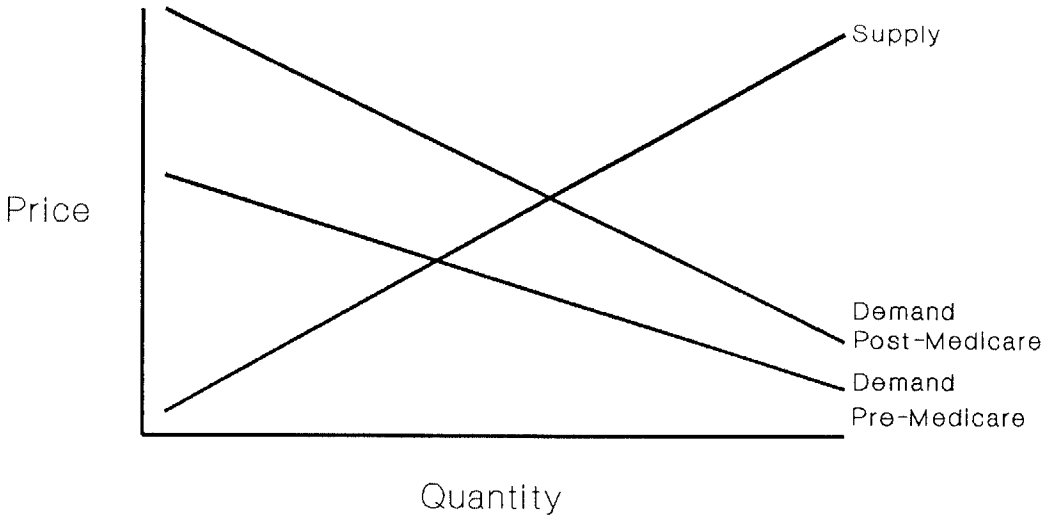
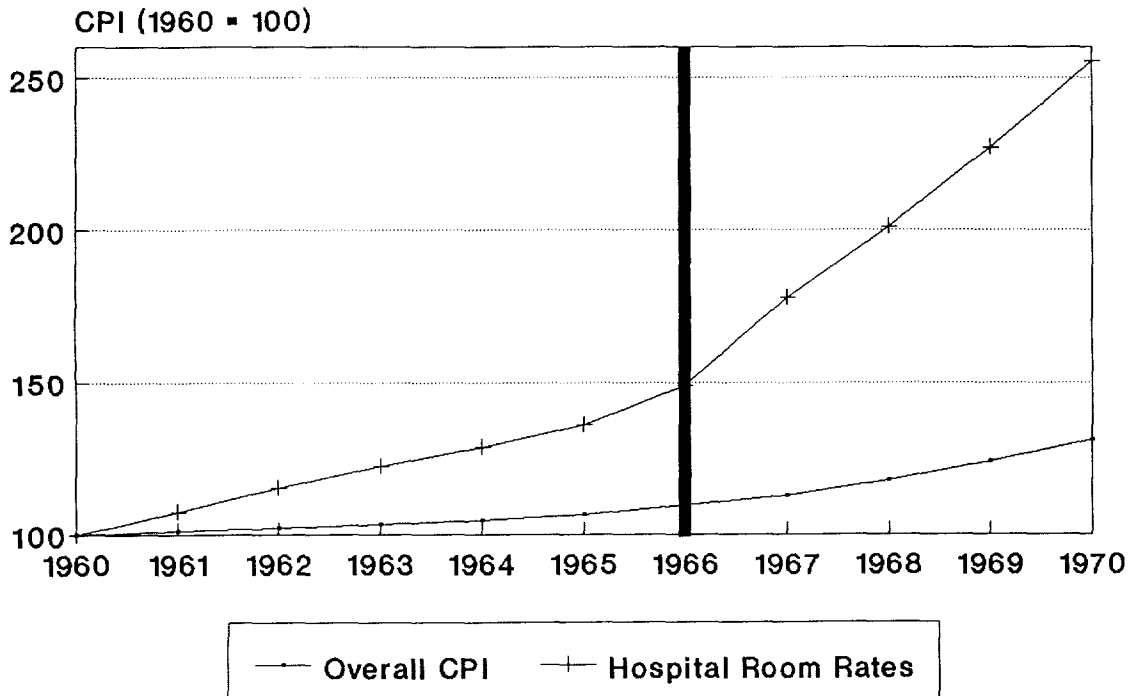
EXHIBIT 1

Medicare Shifts Demand for Health Care

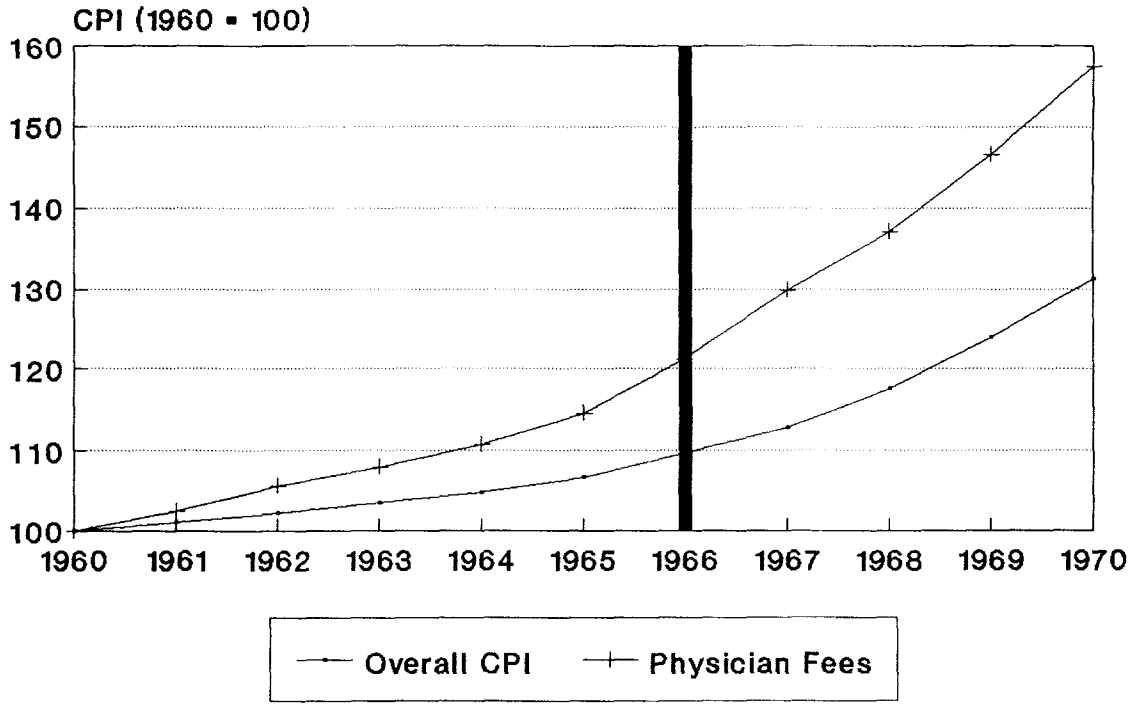


Hospital Room Rates Surge Following Adoption of Medicare



SOURCE: Bureau of Labor Statistics
Statistical Abstract of U.S.

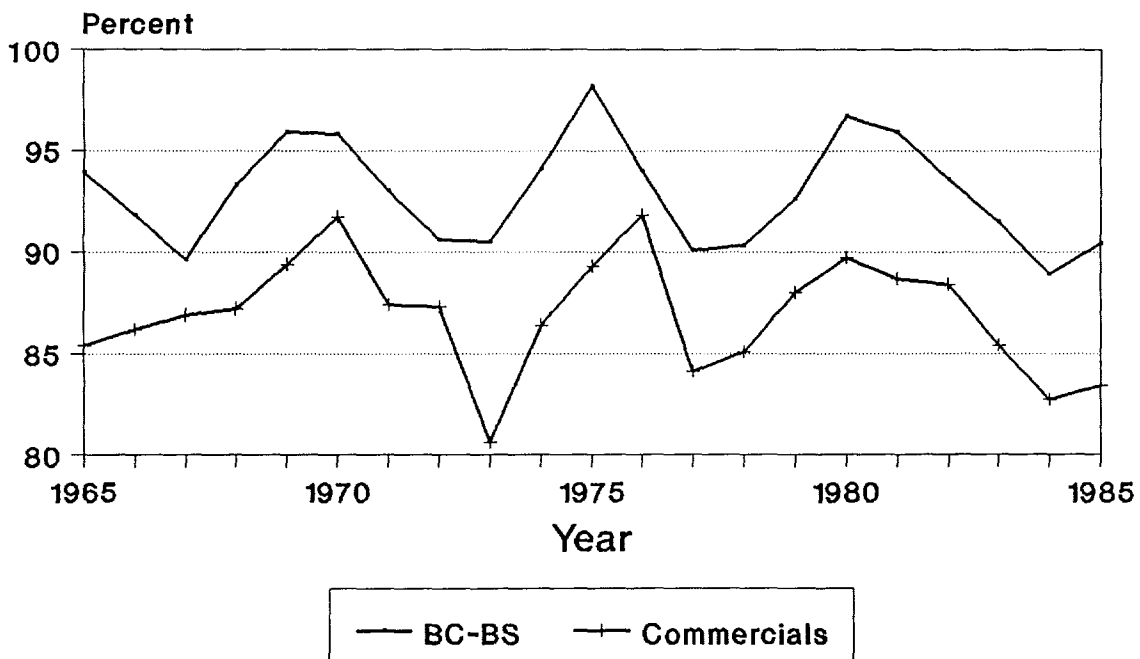
Physician Fees Increase Following Adoption of Medicare



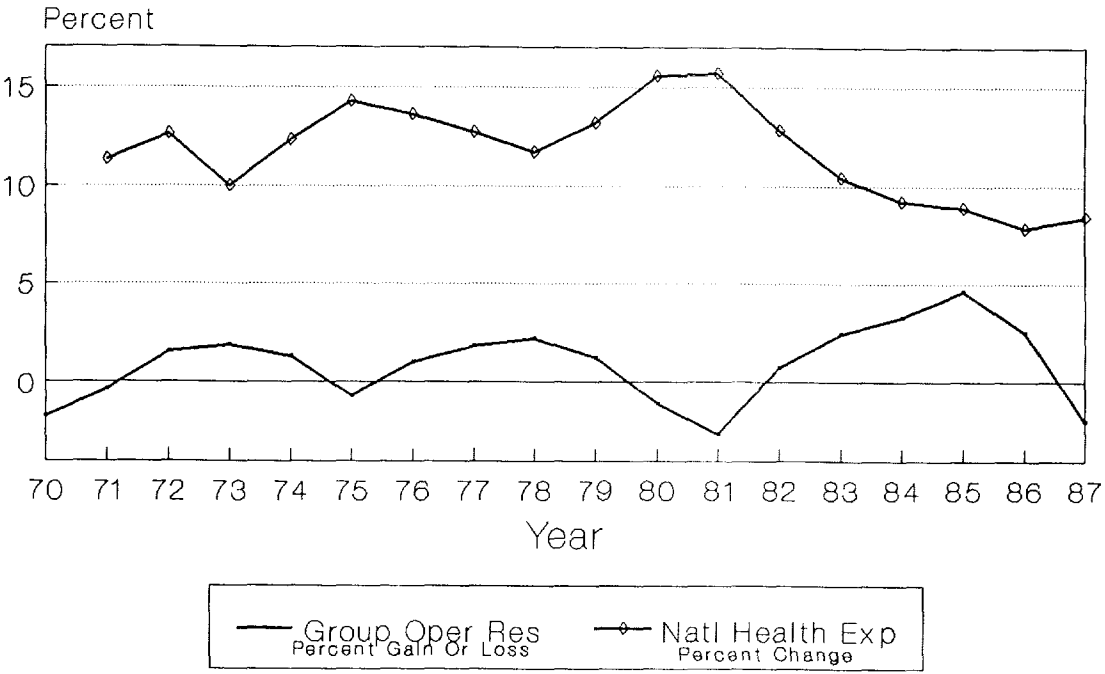
SOURCE: Bureau of Labor Statistics
Statistical Abstract of U.S.

GRAPH 3

Blue Cross-Blue Shield And Commercial Insurers Loss Ratios, 1965-1986, For Group Business



Group Health Insurance Performance Measured Against Changes In National Health Care Expenditures, 1970 - 1987



want to make here is that you could look at this and conclude that when America has trouble with spending and health care costs, the American insurance industry has bigger problems. As John Gable, who is in the audience, characterizes it, "when the health care economy gets a cold, the health insurance world gets pneumonia." In any event, the point is that all this is very much tied together, again emphasizing the cyclical nature of the problem we deal with.

A year of record losses for Blue Cross and the commercial world was in 1987. We believe this ties to the outbreak in the last four or five years of a rapid increase in prices, once again in the provider community, as well as a profound change in the package of services being delivered in the provider community.

Graph 5 is very important and virtually all the rest of the exhibits make a point in this direction. This suggests that a number of companies are leaving the commercial health insurance world. It's not surprising, given the data you've seen prior to this in terms of profitability.

This is an ongoing discussion in the world of commercial health insurance, but perhaps not as high a level of discussion as in the world of Blue Cross. I think their degrees of freedom are reduced in terms of whether to exit the market. But, certainly, there is a vital discussion in the world of health insurance.

Graph 6 shows outpatient revenues inside the hospital and outside the hospital. In 1982, 1983, and 1984 the payer community, principally led by the federal government, began to force a different calculus into the world of providers. This is the second time we saw financing decisions really move the provider community in a profound way. (The first time was 1965.) The second time really begins in the 1980s when we put in place prospective payment. Everybody said, "Oh my goodness, what we've bought ourselves is vast increases in the hospital budget. What those hospitals will do, since we've put a specific price to each admission, is shorten the length of stay and increase the number of admissions, increasing their flow."

What in fact we've seen is that hospitals have reduced admissions. They've reduced length of stay. They've done everything the government had asked them to do. They've increased the cost by intensifying the visit enormously such that in real terms, with fewer people going to the hospital, staying much shorter stays, aggregate real hospital budgets for inpatient use are higher than ever before.

At the same time, there has been an enormous move to the outpatient department of hospitals and to outpatient clinical practice in physicians' offices at magnitudes that never existed in history, showing an increase in outpatient performance.

Now, that is a function, in fact, of providers' reactions to a signal sent that we will not pay rates for inpatient care, and additional inducements -- in many cases positive inducements -- to go to outpatient care. Also, it is a function of the fact that in the last eight years we have introduced into this society 40% more physicians. Of course, being a compulsive economist and being in Chicago, I invoke the name of those economists on the midway who suggested to us that with any profession there is such a thing as a permanent income hypothesis.

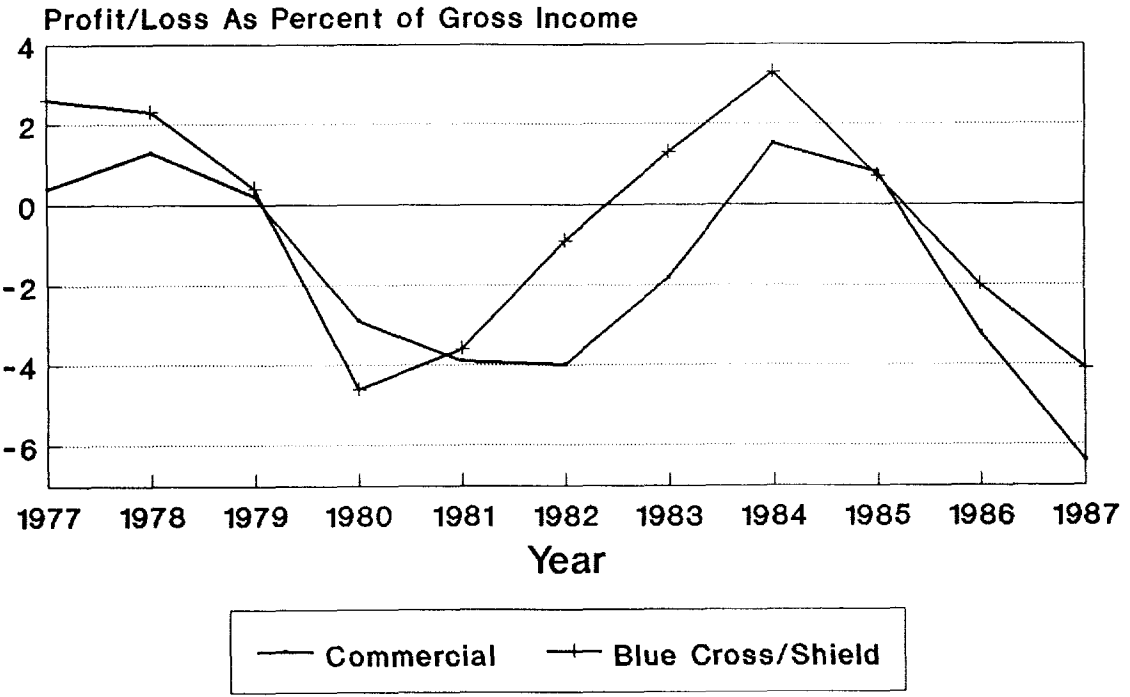
In the case of the physician community, we may contain the exchange price for an entity of service, but we will watch the delivery of many more entities.

Now, Graph 7 suggests part of what our problem is. A very small portion of the population seems satisfied.

The correlator, of course, is that most Americans are terribly unsatisfied with the cost of medical care. Some data recently published says 61% of Americans prefer the Canadian system. I was so interested in this that I asked my research department to get me the field survey, and I now understand why 61% of Americans want the Canadian system. The people who answered the question that Lou Harris put to them had to answer the following question: "I am now about to describe the system to you. You can get as much medical care as you want and it doesn't cost you anything. Do you prefer that over the American system?"

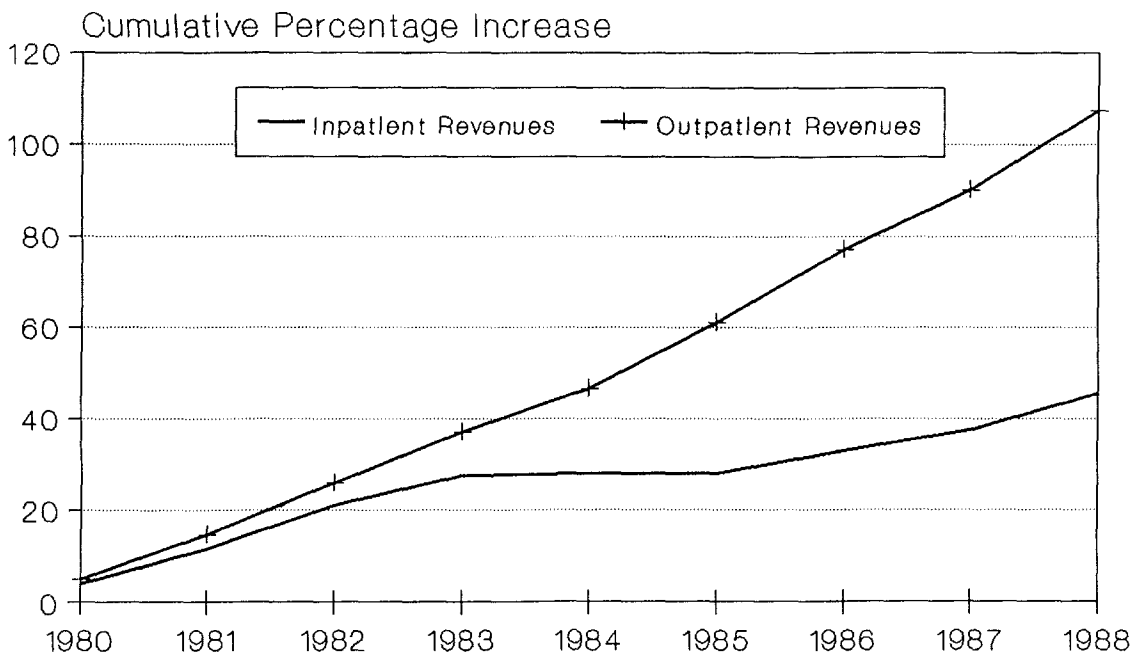
This slide tells us that people were predisposed to answer yes. All right.

1987 -- A Year Of Record Losses For Health Insurers

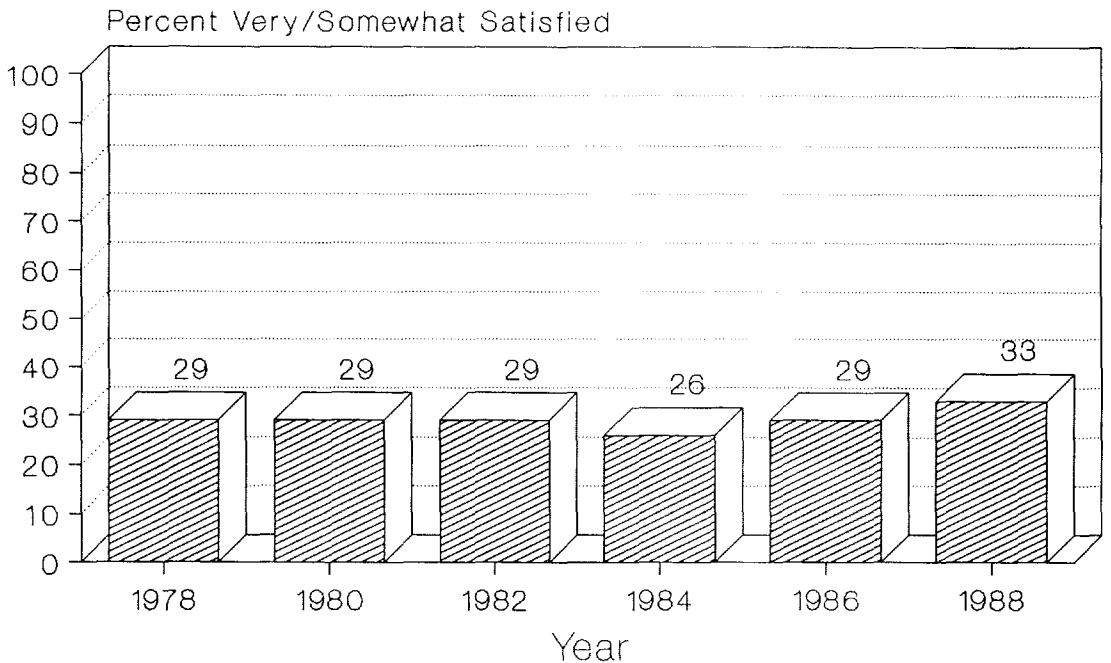


GRAPH 6

Outpatient Revenues Have Increased More Than Twice the Rate of Inpatient Revenues During the 1980s



Americans' Satisfaction With The Cost of Medical Care: 1978-1986



Source: HIAA-MAP Survey

Kane, Parsons and Associates asked 1510 households in 1986, "Do you think we as a society are spending too much, not enough, or the right amount of money on health care?" The response was: too little, 54; about right, 29; too much, 9; not sure, 4.

By the way, the Lou Harris poll did not tell Americans that if we were to get the Canadian system, we would have to pay more for it. When other pollsters ask that question they're always happy to say, "yes, Americans are ready to pay more for a government system." A few other pollsters are sensible and ask, "how much more?" It comes down to about $40.00 a year.

American's have conflicting views about the role of government -- should government see that everyone who wants a job has one? Yes. Are you willing to pay more taxes to do it? No. Do you want the government to give you free health care? Yes. How about taxes? Oh, sure, $40.00 a year. I mean, that covers about 80% of one days cost in a cheap, cheap rural hospital. It covers about two minutes at Columbia Presbyterian.

Health insurance should pay for any treatment that saves lives, even if it costs one million dollars to save a life. Louis Harris and Associates did a poll in 1987 and 71% of Americans agree, 26% disagree and 3% weren't sure. Whatever it costs, we ought to pay it.

It's troublesome if you're trying to play the big policy game in the realm of constrained resources. It is one of those disabilities that economists take into the world of policy. Remember, economists did not invent the deficit. Politicians invented the deficit.

The number of organ transplants since 1984 is shown on Graph 8. There has been an incredible increase in organ transplants. This tells us that Americans are enamored with technology. They want continued life. They don't care what the cost of it is. The average organ transplant, across all the things that get transplanted, is about $100,000.

Anybody who is operating in a claims department of one of our member companies knows that it costs a lot of money and that they didn't pay it out five years ago. These same people know that psychiatric benefits are really rocking the ship. These same people know that low birth weight babies have disproportionate effects on the total claims costs in their company in any given year. We, in fact, are seeing the fruits of enormous invention in high-tech high-cost medicine show up in our claims departments.

This suggests more bad news about the future. As this society gets older and ages, we are in fact seeing quite an extraordinary change from the data in 1980 to the data in 1985 over a whole range of relatively chronic diseases. This would suggest to you that as we get older, we in fact appear to get sicker. No big surprise.

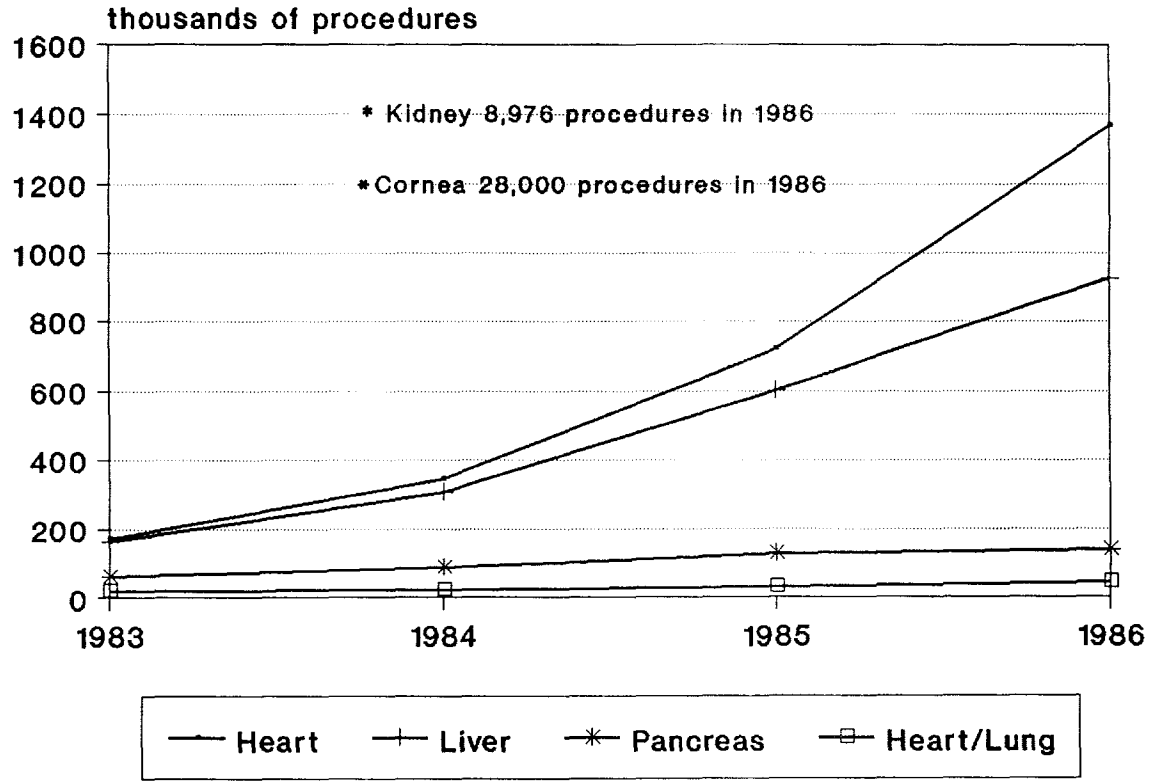
One of the problems we worry about is that Americans are shopping for quick fixes. One of our pet peeves in the insurance world, of course, is mandated benefits. Now, this is going to loom larger than it really is as an issue.

Psychologists say, by the way, if you cover psychologists, who are all 60% per hour cheaper than M.D. psychiatrists, you will have saved the citizens of Maryland, Idaho, Indiana and Ohio, money. You will have given away a free benefit to the population and shuffled the costs, if there are any -- and they would be de minimum -- on those carriers that are licensed to do business in those states.

That virus has spread enormously in the last ten years. We now have, in 1988, 640 mandated benefits (See Graph 9). They drive your claims departments crazy because there are thousands more people working in our industry just keeping track of whether or not hair transplantation is covered in any other state besides Minnesota. State mandated benefits in fact do look like they spread as a virus, something like real diseases. (See Exhibit 2.) In Dukakis-type states you see much higher numbers of them. In states closer to the District of Columbia they seem to be a little higher. Maryland is the granddaddy with 38 mandated benefits.

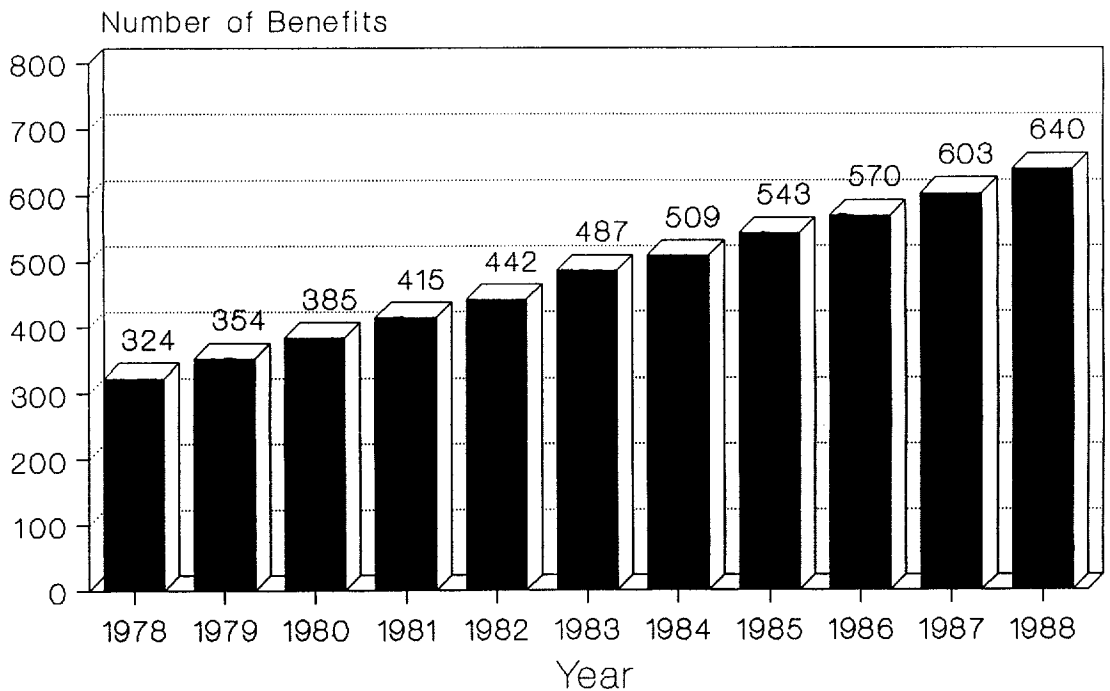
This suggests, from some data done here at the AMA, actually, the percentage change in the price of family coverage by adding specific benefits. If you add substance abuse, it's almost 9% more on the cost of the family in the insurance contract of coverage. There is a twelve percent increase for psychiatric visits, and so forth.

Number of Organ Transplants



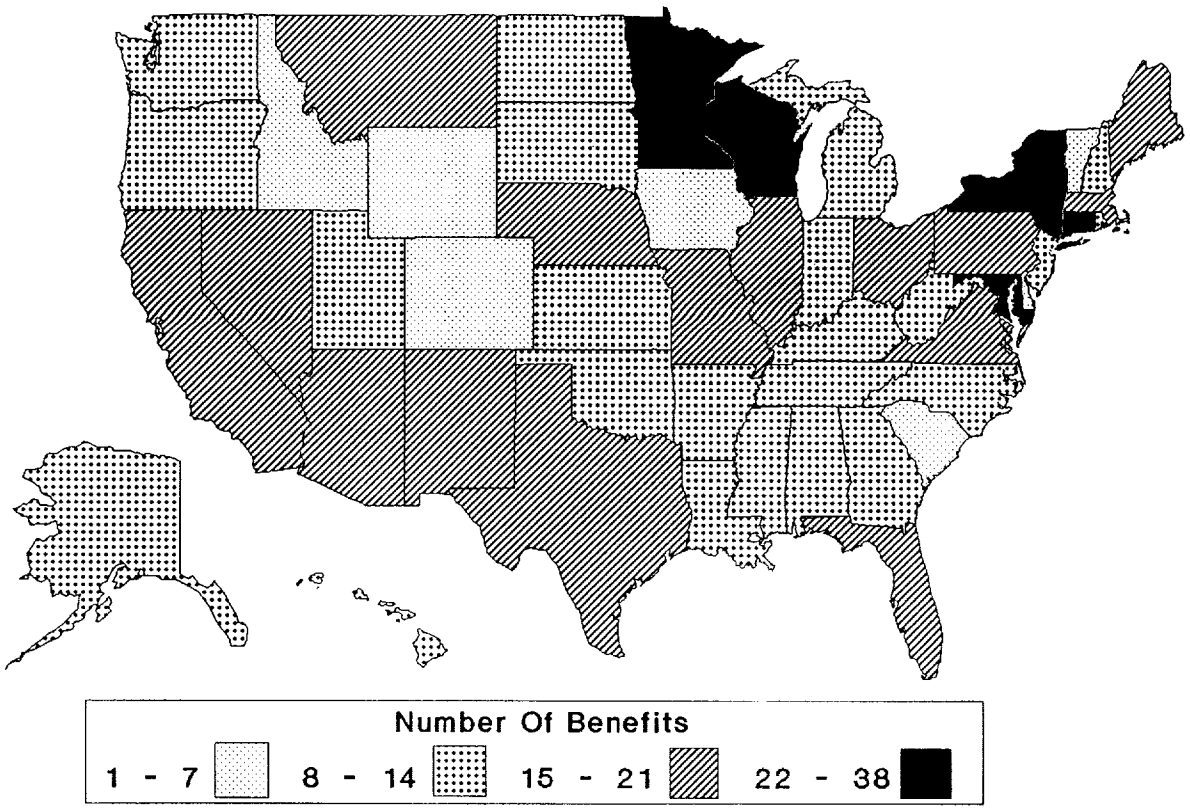
* SOURCE: Dept. Health and Human Services
Organ Transplant Office

Growth of State Mandated Benefits, 1978-1988



Source: Blue Cross and Blue Shield Assocation, January 1989

State Mandated Benefits: 1988



This is not de minimus in many respects. An estimate recently published suggests that of the 37 million people without health insurance, 9.1 million of the 37 million people would be covered but for the phenomenon of mandated benefits at the state level.

Graph 10 shows the effect of mandated benefits on the likelihood that a small firm will provide health benefits to their workers; again, suggesting, I think rather powerfully, why that 9.1% is uncovered. It's because the cost becomes prohibitive when you add on these benefits, which appear cheap -- or free -- to the political system.

I think the most important observation here, as I said at the beginning, is the presence of a cycle. We have to deal with that from a policy perspective, and it is the preeminent issue in terms of the chaos-generator on the scene.

Why do I say that? Every time we see a swing in the cycle, we see two things happen that are enormously disruptive to the long-term interests of private insurance. I'll make the case that the interests of private insurance are the best interests of the country.

First, we induce perverse behavior in the provider community, which is to say they know they're going into a period of hard times. Either public or private payers will put in place some discipline.

We have seen and documented many times over the phenomenon of prospective balancing of the books against hard times; the building of reserves in hospitals. The real question is, should hospitals make profit? There was no discussion about margin in the hospital industry -- they were largely nonprofit about 12 or 15 years ago. Hospitals operated without 4% and 5% margins. They operated at 1% margins, and there are good reasons why that's been changed. Part of it relates to the cycle. They put money away for bad times when in fact payers will come in and impose discipline.

Now, the really bad news is that once these floors are established it's the ratchet effect in economics. No matter what we do to discipline, we never go back down to a previous spending that in real terms is the old level of spending. So, these floors keep getting escalated and we always play last year's ball game.

The second bad effect of the cycle, of course, is that it induces enormous discussion about a big ticket problem in our society. We now have a full-blown discussion about Canada that really is probably a function of the cycle.

Last year we had huge press stories talking about the high cost of insurance -- premiums going up 22% a year. We have generated out of that a discussion about whether or not we ought to scrap the entire system. The very high stakes are connected to the cycle, and again, are the fruit of chaos.

The second thing I want to point out is that at stake is the issue of private insurance, Blue Cross, and the commercial companies. Will this system be displaced by the government as the ultimate payer? Will our customers and the society in general say government could do a better job? There are completely different motivations, obviously, between an employer and a citizen.

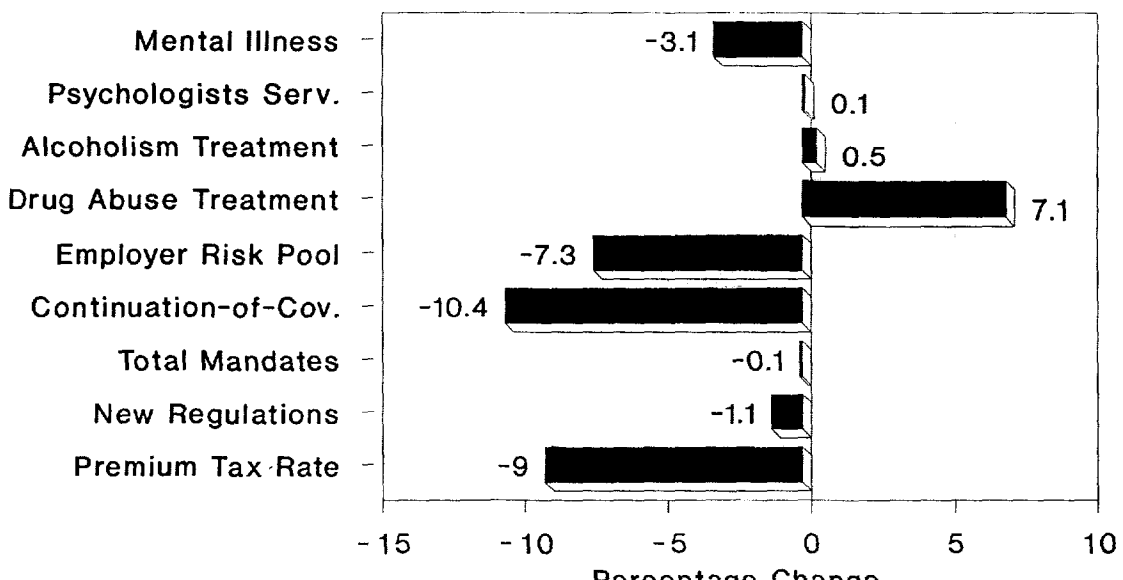
What's at risk, of course, is the ultimate question of how much we spend on health care. We could, in fact, spend lots more, and I would suggest lots more unproductively.

The final issue which we really have to focus on is what we get for all this spending. I would suggest that the question isn't immediately who should pay, but rather how much we should pay collectively.

We're now spending almost 12% of the GNP. It's about 7% more than when this cycle phenomenon got kicked off in 1965, with precious little evidence that the American population is any healthier. Indeed, the one universally agreed-upon indicator of health status has ticked downward; namely, infant mortality.

There's a lot of evidence that suggests that much of the medicine we have bought was therapeutically unnecessary. Indeed, much of it has been scrapped. Much of what we paid for as

Effect Of Mandated Benefits On The Likelyhood That A Small Firm Will Provide Health Benefits To Their Workers



innovations a short time ago, five years ago, have been declared to be dangerous and therapeutically inefficacious. The medicine that was state-of-the-art is now liable in legal standards five years later.

We have no mechanism for vetting the technological advances, and we have every indication that the culture is bound up tightly with absorbing and wanting every technological innovation.

The real question we have to pose for ourselves is, what is the point of all this discipline? The point is to undue the chaos. The real question is how much should we be spending and what is the value we get?

At this moment we don't have that discussion on the national agenda. I think it's an important discussion to start both in the provider world, in the hospital world and in the doctor world, and certainly in the insurance community with actuaries taking the lead.